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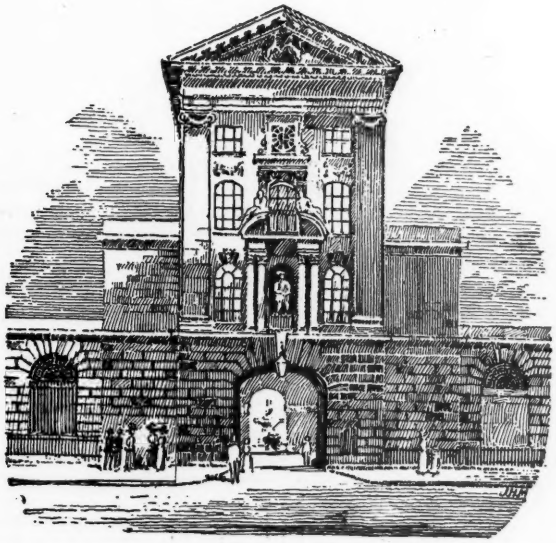

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St. Bartholomew's Hospital

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

JOURNAL.

VOL. XXX.—No. 3.] DECEMBER 1ST, 1922. PRICE NINEPENCE.

CALENDAR.

Fri., Dec. 1.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.
Clinical Lecture (Medicine), Sir Thomas Horder.

Sat., „ 2.—Rugby Football Match *v.* U.S. Portsmouth (home).
Association Football Match *v.* Old Brentwoods (away).
Hockey Match *v.* Enfield (home).

Mon., „ 4.—Clinical Lecture (Special Subject), Mr. Elmslie.

Tues., „ 5.—Prof. Fraser and Prof. Gask on duty.
Annual Dance at Prince's Galleries, 9 o'clock.

Thurs., „ 7.—Professorial Lecture: Prof. Fraser, "The Clinical Aspect of Syphilis of the Lungs, Alimentary Tract and other Viscera."

Fri., „ 8.—Dr. Morley Fletcher and Mr. Waring on duty.

Sat., „ 9.—Rugby Football Match *v.* Bedford (away).
Association Football Match *v.* Old Aldenhamians (home).
Hockey Match *v.* Epsom (away).

Mon., „ 11.—Clinical Lecture (Special Subject), Mr. Scott.

Tues., „ 12.—Dr. Drysdale and Mr. McAdam Eccles on duty.

Fri., „ 15.—Sir P. Horton-Smith Hartley and Mr. Waring on duty.

Sat., „ 16.—Rugby Football Match *v.* Catford Bridge (away).
Association Football Match *v.* Toc. H. (away).
Hockey Match *v.* Wembley (away).

Tues., „ 19.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.

Fri., „ 22.—Prof. Fraser and Prof. Gask on duty.

Mon., „ 25.—Christmas Day.

Tues., „ 26.—Dr. Morley Fletcher and Mr. Waring on duty.

Fri., „ 29.—Dr. Drysdale and Mr. McAdam Eccles on duty.

EDITORIAL.

CHRISTMAS comes but once a year, and when it comes it invariably produces not only great happiness in the Hospital, but an Editorial paragraph explaining that it is coming (which indeed every living soul in the Hospital knows already), why it is coming, and what may be expected when it does come.

We propose this year merely to wish our readers a very happy time, and in passing, to say how glad we are that Sister Theatres will be back in time to render (with her Staff) her customary invaluable assistance to the Troupes.

* *

We are happy to know that some time before the New Year, the President of the Hospital, His Royal Highness the Prince of Wales, will unvail a memorial tablet in Sandhurst Ward to our late Treasurer, Viscount Sandhurst.

* * *

Full reports of the Oxford and Cambridge Dinners will be found in our next issue. Both passed off well. A record number attended each. This was perhaps inevitable in the case of the Oxford feast, since it happened to be the first, but was gratifying in the case of the older Cambridge Club.

*

Dr. J. H. Drysdale has been elected an Examiner in Medicine to the Royal College of Physicians of London in place of Dr. Morley Fletcher.

* * *

Our congratulations to Dr. F. G. Chandler upon his appointment as Assistant Physician to Charing Cross Hospital are mingled with our deep regrets that this will

mean that he will cease to be one of our own Casualty Physicians.

* * *

We print elsewhere in this issue a photowhich represents (if there are counted together the number of years' service to the Hospital of its individual members) more than 214 years' work.

The occasion of this photo was remarkable. It marked the completion by Mr. W. Peat of 41 years as a "box-carrier" and porter to the Hospital. Many of his colleages and friends on the Junior and Senior Staff thought that this should not pass without recognition. On their behalf, therefore, Mr. Peat was presented on October 27th with a suitably engraved gold watch, a wallet containing treasury notes, and a purse of money from the Sisters. The Steward made the presentation, and Messrs. Langford Moore, Allen, Watkins and Herbert spoke of their regard for Mr. Peat of his long, faithful and concientious service.

In leaving us Mr. Peat must carry away many memories of bygone times: of days when asepsis was not recognised, and each surgeon was accompanied on his rounds by his "box-carrier," of the war-years and the air-raids, of the old and the new surgery. It leaves with us pleasant memories of faithful work well done.

It is a great thing for any man to have completed 41 years' service in an institution where of necessity each must be critical of his neighbour and yet be held in the respect and affection all feel for Mr. Peat. We hope that he may enjoy many years' rest after his long and honourable career.

* * *

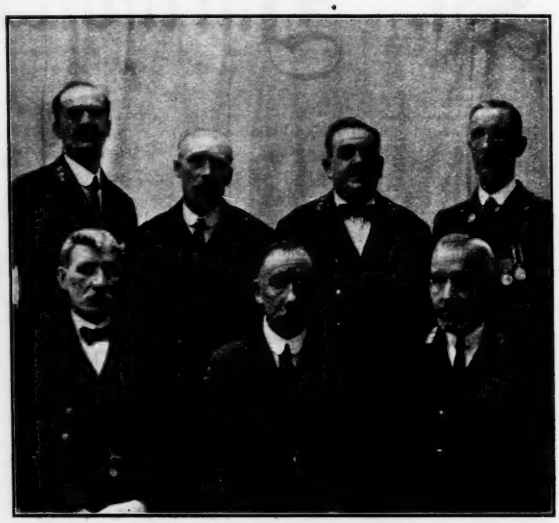
During the past months we have received letters from India, China and Africa and from many towns in Great Britain asking the question, "Please, when are you going to publish *Round the Fountain* again?" Requests of a similar nature have made our life a burden to us in the Hospital.

We hope that a new and fuller edition of this extremely popular compilation of humorous medical prose and verse will be ready before Xmas and we shall try to keep to the price of half-a-crown. If we are able to do this it will be the most remarkable instance we know of stability in pre- and post-war prices.

We need not say that every member of the Senior and Junior Staff should have his copy. Such may be taken for granted. We would, however, remark that every Nurse should have her's too.

And no present will be more acceptable this Xmas than *Round the Fountain*.

Readers should order their copies early, from the Editors, Journal Office, St. Bartholomew's Hospital. If the order is by post, remittance should be enclosed with postage.



THIS PICTURE REPRESENTS 214 YEARS' SERVICE TO THE HOSPITAL.
J. WILSON, WM. PEARSON, W. G. HERBERT, W. M. EVANS,
W. TUTTON, MR. W. WATKINS, W. PEAT.

THE OCTOCENTENARY OF THE FOUNDATION.

7. THE WARDS.

By SIR D'ARCY POWER, K.B.E.

OLD names lingered for a long time in the newly-constituted Hospital. There was the Garden Ward and the Cutting Ward; the Women's Ward and the Dortoir, which had become corrupted into the "Dorter," and later, when its origin was wholly forgotten and clerks prided themselves on their spelling, into "The Daughter Ward." As the Hospital grew new wards were built and new names had to be given. In 1572 there were "High Ward," "Childhouse Ward," "Sellers Ward," "Long Ward," "Armyte's Chamber," "Chapel Ward," Garden Dortoir Ward," "Cloister Dortoir Ward," "Sweating Ward," and "Sister's Chamber." During the Dutch War soon after the Restoration, King Charles the Second, through the Privy Council, asked that a moiety of all the rooms in the Hospital should be reserved during the time of the war at sea, and that "they shall be disposed to such as shall be wounded in the Service of the Navy." The answer was returned that rooms for eighty persons shall be forthwith ready for His Majesty's Service for such sick and wounded seamen and soldiers, and that six wards shall be speedily made ready for their entertainment, viz.—King's (2 Wards) Long Ward, Cloisters Daughter Ward, Queen's Ward, Martha's Ward and Katherine's Ward, which wards are conceived fit for the reception of ninety-one persons and every one to have a single bed. Two years later, when the

Hospital had to be partially closed owing to the depopulation of the City and the loss of revenue it had sustained by the Great Fire of London in 1666, mention is made of a Long Ward, a Curtain Ward, a Mark Ward, a Martha Ward, a New Ward, a Dyett Ward, a Naples Ward, a King's Ward and the Garden Dorter Ward. The King's Ward was to be converted into shops.

Sir William Church says in an interesting paper contributed to the *St. Bartholomew's Hospital Reports* in 1884: "I have been unable to find any record of the number of beds existing at the end of the eighteenth century or the number of patients annually admitted, but there were fifteen sisters, representing at least fifteen wards, and it seems evident that the various medical officers must have had their patients scattered through many wards and not collected together. Dr. Bernard's patients, who were all men, were to be found in ten wards. In all probability medical and surgical patients were mixed together, for unless that was the case, it is difficult to see how fifteen sisters could manage and look after the number of in-patients that the Hospital then contained. There is no record of the exact number, but Dr. Bernard had above one hundred patients in his own charge, all men. His colleague, Dr. Browne, son of Sir Thomas Browne, who wrote the *Religio Medici*, may have taken charge of the female patients, and as junior would probably have a much smaller number of beds—perhaps not more than fifty. The three surgeons would certainly have at least one hundred and fifty beds between them; a certain number would be required for the cutters for stone and the foul wards, so that we may safely conclude that the total number of patients was over three hundred. The same result is arrived at in another way. The daily allowance for the patients' diet was fourpence apiece, and for three hundred patients this would make the sum £1825, and the actual cost of "Dyetts for the Poore" in 1682 was £1814 2*s.* 2*d.* The average number of patients therefore at this time was about three hundred, and if there were fifteen wards there would be about twenty beds in a ward."

The names Rahere, Radcliffe, and President Wards were given when the present buildings were opened in 1740, and when the third block was opened two years later it was ordered that the wards should be called Marshall, after Sir Henry Marshall, who was President of the Hospital; Watt, after John Watt, Colston and Aldred, all of whom had been benefactors. There were also Mary, Elizabeth, Martha, Magdalen, Faith, Hope, Charity and Patience. Marshall, Watt, and Patience were renamed long ago, Magdalen remained until the venereal wards were abolished in our own time, whilst Colston still keeps green the name of Edward Colston, the Blue Coat boy, philanthropist and West India merchant, in whose honour Colston Day is still celebrated annually at Bristol. He was one of the auditors of the Hospital accounts in 1692–3.

The wards of the Hospital have witnessed many tragedies, but none have come home so closely to the members of the Staff as two which happened comparatively recently on Saturday, May 24th, 1862, when Edward Stanley, who had recently been appointed Consulting Surgeon to the Hospital, had a cerebral hæmorrhage whilst he was watching an operation in what is now Theatre A. He was carried into Henry Ward, and died an hour later in the state bed in the front ward. Stanley, indeed, died full of years and honours, but on April 19th, 1913, R. B. Etherington-Smith died in Charity of blood-poisoning after two days' illness—Junior Assistant Surgeon, Captain of the Cambridge University Boat Club, a man of the greatest promise and beloved of all. The ward for the nursing of the Resident Staff is a fitting and lasting tribute to his memory.

ACUTE INFECTIVE OSTEOMYELITIS OF THE LONG BONES: AN ANALYSIS OF CASES.

By RODNEY MAINGOT, F.R.C.S.,
Chief Assistant to a Surgical Unit, St. Bartholomew's Hospital; Surgical Registrar, West London Hospital;
and
FRANK GREEN.

THE results of operation upon the long bones for acute osteomyelitis are often disappointingly unsatisfactory. Too often a patient dies, and the "post-mortem" discloses areas of suppuration lying above or below the limits of drainage, which have given rise to a fatal staphylococcal pyæmia. Too often, again, a patient is discharged "healed except for a small sinus," only to be admitted twice or three times later on for sequestrectomy.

With a view to comparing the immediate and permanent results of the various forms of operative treatment adopted in this disease, the writers have collected the notes of forty cases of acute osteomyelitis, which have been treated in St. Bartholomew's Hospital since 1904.

The results of this analysis they venture to present in the following statistical paper. In addition to notes on the operations they have included such other data as appeared to them to be of interest with regard to this condition.

Forty cases were examined, and they were chosen carefully because of the completeness of their notes, all for any single year being, where possible, included so as to give a more or less accurate estimate of the proportion of male cases to female, etc. Of these:

Total cases, 40.

12 died in hospital, = 30 per cent.

10 were discharged *completely* healed after first admission, = 25 per cent.

3 were still ill at the time of writing, with uncertain prognoses, = 7·5 per cent.

13 were discharged with sinuses (of these at least 6 were subsequently readmitted for sequestrectomy), = 32·5 per cent.

1 was discharged after amputation of the affected limb = 2·5 per cent.

1 was discharged as "healed" but was subsequently readmitted for (*a*) sequestrectomy; (*b*) bone graft for ununited fracture of tibia following diaphysectomy; = 2·5 per cent.

Ætiology of these Cases.

31 of the cases were males (77 per cent.). The commonest age was from 9 to 14 (62 per cent.). The extreme ages noted were 2 years and 49 respectively; incidentally both the latter cases were females.

A definite history of trauma was established in 17 cases (42·5 per cent.).

"Septic foci" (*i.e.* sore throats, carbuncles and boils) were held responsible in three cases, whilst one was said to have followed an attack of rheumatic fever.

Bones affected:

Tibia . .	in 20 cases	= 50	per cent.
Femur . .	„ 11 „	= 27·5	„
Humerus .	„ 3 „	= 7·5	„
Radius . .	„ 2 „	= 5	„
Fibula . .	„ 2 „	= 5	„
Metatarsal .	„ 3 „	= 7·5	„
Rib (left seventh)	„ 1 case	= 2·5	„
Phalanx .	„ 1 „	= 2·5	„

Of these, the right tibia and proximal phalanx of left index finger were affected together in one case, the left tibia and fibula in a second, the left tibia and right fifth metatarsal in a third, the left femur and left fibula in a fourth, whilst in a fifth both femora were affected simultaneously.

Infecting Agent.

In 13 cases no bacteriological investigation was carried out. Of the remainder, pure *Staphylococcus aureus* infection formed 78 per cent. In only one instance was the infecting organism stated to be *Staphylococcus pyogenes albus*. In three others the infection was mixed, viz.:

Staph. aureus and streptococci.
„ „ „ a diphtheroid bacillus.
„ „ „ *B. pyocyaneus*.

History of Illness and Condition on Admission.

In the majority of these cases the "history" of illness was of about three days' duration. The following is a very typical example:

Boy, æt. 13:

4 days before admission: fall on right knee while roller-skating.
3 „ „ „ Right thigh painful and tender. Patient was "feverish" and stayed in bed.
2 „ „ „ Right thigh very swollen, tender and red.

Next day seen by his doctor, who advised hospital treatment.

In some instances, however, the history of pain and malaise (preceding admission) was much longer than this. In three cases it exceeded a week.

Though none of the latter terminated fatally, all three ran prolonged courses, and were eventually discharged from hospital "with sinuses."

As regards the condition on admission there was a marked degree of similarity between most of the cases.

The average temperature was 102°, with a pulse of about 110. At least one acute case was admitted with a temperature as low as 97°, but it rose rapidly after admission to 102°.

The most constant local symptom was *bony tenderness* over the affected region and sometimes referred to a more distal portion of the bone; it was present in all cases except two. In both the latter the osteomyelitis (of femur and fibula respectively) was complicated by suppurative arthritis of neighbouring joints (knee and ankle), and the only tenderness to palpation complained of by the patient was over these joints themselves, though the *entire* shaft of each bone was found at operation to contain pus. In one other case, though, bony tenderness was not observed clinically owing to the moribund state of the patient, it was in all probability present. This case seems of sufficient interest to merit special description.

The following is a brief summary of the notes:

Patient, a boy, æt. 11, was admitted to a medical ward, acutely ill with bilateral pleurisy.

There were indications of a possible meningitis, and on attempting to elicit Kernig's sign it was noticed that the patient screamed when the thighs were lifted.

There was no swelling or redness of either thigh; the condition of the patient prevented more thorough examination. No operation was attempted.

A few hours later the boy died, and the post-mortem disclosed—

(1) Acute osteomyelitis of left femur.
(2) Subperiosteal abscess of right femur.
(3) Acute pleurisy on both sides.
(4) Abscesses in both kidneys.
(5) Septic infarcts in lungs, heart-wall and spleen.

There was no evidence of arthritis in the hip or other joints.

In 5 cases bony tenderness was the *only* local sign, but

in the remaining 35 (88 per cent.) all the "classical" symptoms of heat, swelling, redness and impairment or loss of function were present in variable degree.

X RAYS.

As an aid to the diagnosis of acute osteomyelitis X rays are practically valueless. Excellent assistants as they are in the later stages of the disease, particularly where diaphysectomy has been performed, when they facilitate observation as to the amount of new-bone formation and the detection of sequestra, in the early stages they tend to be rather misguiding. As examples of this may be quoted two cases in which the femur was found at operation to be loaded with pus. In both the latter, X-ray plates taken one day before operation showed "no bony abnormality."

COMPLICATIONS OF ACUTE OSTEOMYELITIS.

The most important *local* complication of acute osteomyelitis is an extension of the suppuration to adjacent joints: septic arthritis complicates about 30 per cent. of acute bone abscesses. This suppurative arthritis due to direct extension is to be distinguished from that occurring later in the disease as part of a general pyæmia. In conjunction with osteomyelitis it is common to find myositis and cellulitis; these are to be regarded as concurrent infections rather than true complications of the bone condition—in many cases, indeed, they precede the latter.

The *general* complications of acute osteomyelitis, which are serious and commonly fatal, follow directly upon the three stages of general infection—toxæmia, septicæmia and pyæmia. It is difficult to state at what point complications due to septicæmia merge into those due to pyæmia, but toxæmic symptoms appear early in the disease and form a very definite entity by themselves. One of the commonest of these is "meningism." Three out of twelve fatal cases, had definite meningitic signs a few days before death—Kernig, strabismus, and head-retraction; in each of these a "post-mortem" was subsequently performed, when the brain and meninges were shown to be normal.

The onset of the septicæmic or septico-pyæmic stage is usually quite definite; a sudden rise in temperature and pulse-rate, with signs of early broncho-pneumonia, pleurisy or pericarditis make the prognosis extremely grave.

Any doubt as to the presence of septicæmia may usually be allayed by obtaining a positive blood-culture. In a few cases of acute osteomyelitis the only diagnosis that can be made is that of septicæmia or pyæmia, and the focus of infection in the bone is not found until the post-mortem examination.

The following is a table of the lesions noted in six fatal cases:

Broncho-pneumonia . . .	in 2 cases
Empyema	„ 4 „
Pericarditis	„ 3 „
Abscesses in myocardium . .	„ 4 „
„ „ kidneys . . .	„ 4 „
„ „ lungs . . .	„ 4 „
„ „ liver	„ 1 „
„ „ spleen	„ 1 „
Metastatic infection of other bones	„ 2 „
„ „ of joints . .	„ 2 „

It is commonly stated that, once pericarditis has developed, a fatal termination is imminent. In opposition to this the writers can say that they have seen two cases with definite pericarditic signs which have later recovered sufficiently to be discharged from hospital "considerably improved."

OPERATIONS AND AFTER-TREATMENT.

The operations adopted in these cases were of three types, viz. (1) the "gutter" operation, (2) diaphysectomy, (3) amputation.

The "Gutter" Operation.

This is further divisible into two, *e.g.* the "major" gutter and the "minor" gutter. The first of these involves the making of a *large* hole or groove in the bone, not limited to the inflamed area, but laying open a considerable portion of the bone-marrow. If sufficiently extensive this operation provides excellent drainage, and has several obvious advantages over diaphysectomy, which will be considered later. The second consists merely of making a *small* hole or incision in any part of the bone which appears inflamed, evacuating as much pus as possible by means of irrigation, and inserting drainage-tubes or plugging into the wound. The hole in the bone is effected by chisel and hammer, gouge, or electric burr or drill. In order to allow free and dependent drainage it should, if possible, be placed laterally or posteriorly.

This "minor gutter" operation, being strictly localised, provides no exit for collections of pus which may be loculated in other parts of the bone. It is quite common to have two or three separate abscesses situated simultaneously in the shaft of a single long bone, and in many cases in which one of these has been drained by a small opening the patient has died of pyæmia following another—which has only been discovered post-mortem. Even in cases which recover one "minor gutter" is seldom enough to produce the desired result; it is no uncommon thing for this operation to have been performed five, six or seven times in the course of a month upon the same bone—at the end of which the condition of the injured bone may readily be imagined!

Hence, though it may suffice in a few cases in which the

infected area is *known* to be small, yet as a general treatment of acute osteomyelitis the minor gutter operation is to be deprecated in favour of the "major gutter" or of diaphysectomy. This statement is borne out by a consideration of the Table published below, in which it will be seen that the minor gutter has a higher percentage of deaths and a lower percentage of cures than the two other operations.

Advantages of the major gutter operation.—(1) There is little risk of subsequent deformity, unless the bone is fractured.

(2) It ensures good drainage from the infected region, *provided that the whole or the greater part of the medulla is exposed.*

(3) It is probably the only suitable operation for patients over forty. In these the slow rate of new-bone formation renders diaphysectomy undesirable.

In theory, then, the "major gutter" should be the ideal operation for acute osteomyelitis. But in practice (see Table) it is found to give less satisfactory results than diaphysectomy.

The reason for this is often to be found in the conservatism of the operator. So seldom is the opening into the bone made large enough, so seldom is it placed postero-laterally. With such inefficient drainage, the patient, even if he survive, is very apt to develop sequestra in the affected bone, with the result that he will probably require as many subsequent operations for sequestrectomy as if the minor operation had been performed in the first instance.

Diaphysectomy.

This operation may be defined as the sub-periosteal resection of the whole or portion of the shaft of a bone. In the cases under consideration it has given relatively the best results of the three methods of operative procedure.

Advantages of diaphysectomy.—(1) The whole infected area is removed, so that the possibility of subsequent pyæmia and death is practically excluded. Reference to the Table will show that out of nine cases so treated the mortality was *nil.*

(2) Thorough drainage is ensured.

(3) One operation is generally sufficient. In this it

TABLE OF OPERATIONS.

OPERATION.	NO. OF CASES.	NO. OF DEATHS.	EXTENT OF OPERATION AND CONDITION OF PATIENT ON DISCHARGE.	REMARKS.	PERCENTAGE OF COMPLETE CURES.
Diaphysectomy	9	Nil (= 0 %)	1. Complete shaft of right radius. Healed. No shortening.	This patient was readmitted 5 years later with a recurrence of symptoms. She had had no further trouble until then. X rays showed almost complete reformation of the shaft of the radius, but that a sequestrum was present. (See text.)	55 %
			2. 3¾ in. of right femur. Complete healing. No shortening.		
			3. 3 in. of right tibia. Complete healing. No shortening.		
			4. Right first metatarsal. Complete healing.		
			5. 1¼ in. of right tibia. Discharged with 2 short sinuses.		
			6. Right tibia. Healed. Right leg had 3 in. shortening. Joint movements good.		
			7. Left tibia; diaphysectomy after 5 "minor gutter" operations. New bone formation was slow and uneven. Patient was readmitted 2 years later for ununited fracture (treated successfully by bone-graft).		
			8. 6 in. right tibia. Discharged as "healed."	This patient was readmitted 6 months later with a recurrence of symptoms. The bone was found at operation to contain a sequestrum and much pus. Finally discharged with a small sinus.	
			9. Left fibula. Healed.		
Major gutter operation	16	4 (= 25 %)	3 were discharged healed. 9 were discharged with sinuses.	—	12·5 %
Minor gutter operation	10	5 (= 50 %)	1 was discharged completely healed. 4 were discharged with sinuses.	—	10 %

compares well with the gutter operation, of which two or three repetitions is the rule.

(4) It is specially suited to the cases of children, since, in them, new bone formation takes place both rapidly and completely from the periosteum and epiphyses.

(5) The final result is in most cases highly satisfactory.

There are two other striking factors to be noted after diaphysectomy has been performed. The first is the precipitate fall in temperature immediately after the operation, and the second the comparative freedom from pain.

Both these factors are accounted for by the radical removal of grossly infected tissue, and by the thorough drainage which is established and maintained when this procedure is adopted.

Disadvantages of diaphysectomy.—The above figures tend to show diaphysectomy in a very agreeable light. What, then, are its limitations and objections?

In the main these are five, viz:

(1) In mild cases in which the infection is strictly localised it is a disproportionately extensive operation. But it is by no means easy to say with certainty of such infection that it *is* strictly localised; there may be further abcesses in other parts of the bone, and a small operation may be insufficient to prevent a fatal pyæmia.

To perform diaphysectomy is to be on the safe side, even though convalescence may afterwards be prolonged.

(2) In some cases there has been no regeneration of the affected bone—probably due to periosteal injuries at the time of diaphysectomy.

(3) There is after diaphysectomy a risk of shortening and deformity. For instance, a case is quoted above in which, after excision of a part of the shaft of the right tibia, the patient was discharged "healed, but with 3 in. shortening of the right leg."

Such deformity can be prevented by applying weight-extension and suitable splinting to the affected limb *as soon as possible* after the operation. In the case just mentioned this was not done until six weeks after the operation, the leg meanwhile being fixed in a Neville splint.

Conversely in a very successful case (of right tibia) in which the patient was discharged with a practically normal leg, it is expressly stated in the notes that extension was applied *early* and maintained for two months.

(4) Diaphysectomy is a relatively unsuitable operation for patients over forty, in whom new bone formation is apt to be slow and imperfect.

(5) Even when diaphysectomy has been performed successfully, followed apparently by a complete cure of the disease, there is a chance of delayed sequestra-formation in the same bone which may lead to a recurrence of symptoms at a later date. In the Table of Operations reference has been made to two cases in which this misfortune occurred.

In one of these—that of the right radius—the patient had an apparently normal arm for *five years* after she left hospital before any symptoms reappeared. Then, quite suddenly, the arm began to get painful, tender and red; the patient became ill, and was admitted to hospital with pyrexia (temperature 100·5°). An operation was performed at once, and a large sequestrum was found embedded in the newly-formed shaft. This was removed, the medulla was salt-packed, and the patient made a rapid and satisfactory recovery.

There is no record of any subsequent relapse.

No defence can be made against this objection to diaphysectomy; the condition has simply to be combated as it occurs. In both the cases of which the writers hold record, satisfactory results (lasting three and seven years respectively up to date) have followed surgical treatment of the first relapse.

Amputation.

Amputation is the final method of treatment of acute osteomyelitis; it is performed where other methods are impracticable or have failed. In the "fulminating" cases it may be advocated as a life-saving procedure. It was adopted in four cases in this series; three of the patients died, one recovered. In each case it followed two unsuccessful "minor gutter" operations.

The following may be regarded as indications for amputation:

(1) Where other methods of treatment have failed, and exhaustion threatens life.

(2) In "fulminating" cases.

(3) In some chronic cases with multiple sinuses, and inaccessible sequestra.

(4) In chronic cases with lardaceous disease present or threatening.

(5) In some cases associated with a severe pyæmia.

(6) When the suppurative process has spread to a large neighbouring joint.

Vaccine Treatment.

The use of an autogenous vaccine after operation frequently appears to be followed by good results; and should in all cases be given a trial. The efficacy of sera is at present doubtful.

CONCLUSIONS.

(1) The minor gutter operation has little to commend it. It gives unsatisfactory results and has a high death-rate.

(2) The *major gutter operation* is good, provided it is sufficiently extensive.

(3) Complete and partial diaphysectomies have given the best results of any operations adopted in these 40 cases. The danger of shortening and deformity after diaphysectomy may be overcome by applying weight-extension as soon as possible after operation.

(4) Diaphysectomy is specially suited to children, in whom new-bone formation is both rapid and complete. It is less applicable to patients over forty.

(5) Amputation is indicated in certain "fulminating cases" as the one chance of saving life.

In conclusion the writers' sincere thanks are due to the surgeons who had charge of these cases for permission to make use of their notes.

THE HOSPITAL OF THE ROCKEFELLER INSTITUTE AND ITS WORK.

By GEOFFRY C. LINDER, M.D., M.R.C.P.,
Assistant Resident Physician.

IT is the fashion for visitors to the United States to publish their views on America and the Americans, and the shorter their experience the more general and emphatic are their conclusions. It appears, too, that editors and publishers have an almost insatiable appetite for such fare. It is not surprising, therefore, that the editor of the JOURNAL should request a contribution about America, or that I, who have been but a few months here, should seize the opportunity of supplying it. Fortunately he was content to ask for an account of the Rockefeller Institute and was not interested in my views upon the ever-recurring topic of prohibition.

The history of the Institute is a short one judged by its years, but the tale of its accomplishments is already long. It was founded in 1901 by Mr. John D. Rockefeller to conduct and encourage investigations in hygiene, medicine and allied subjects, and to make such knowledge available for the protection of public health and improvement of the treatment of disease and injury. At the commencement the resources of the Institute were employed in making grants to investigators in different parts of the world, but in 1904 temporary premises were obtained and research work was commenced under the directorship of Dr. Simon Flexner, who remains in that position at the present time, and has guided the Institute to its present enviable position in the world of science and medicine. Two years later the present Laboratory Building was completed, and it was then determined to provide a hospital for the precise clinical study of human disease as nearly as possible under the conditions of the laboratory. The Hospital was opened and patients admitted in October, 1910. Since then another building, containing an assembly room, laboratories, and an animal house has been built, and a department for the study of animal diseases, under the direction of Dr. Theobald Smith, has been organised. The latter is situated at Princeton, about thirty miles from New York. The story of the work done would be far too long for this article; the names of Flexner, Noguchi and Carrel will alone suggest its range and importance.

The site selected was a large block of sloping land overlooking the East River, which connects New York Bay with Long Island Sound, and through which passes a stream of coastwise shipping. The buildings stand close to the edge of a low cliff, and command a magnificent view of the river and bridges. On the other sides they are separated from the city by open ground belonging to the Institute, but at present used for allotments and children's playgrounds.

The Hospital has its own laboratory accommodation and a corps of chemists, bacteriologists and pathologists, who work in association with the clinicians in charge of the patients; it is thus to a large extent independent of the Institute, but the Library, X-ray Department and certain other minor services are common to them both. The Hospital staff lunches in the Institute, so that the men of the two divisions meet daily and exchange ideas. The wealth of equipment in all departments is very striking to anyone accustomed to work in a less munificently endowed establishment. The Hospital building differs considerably from the type to which we are accustomed in London. It is a narrow oblong pile of eight floors, and has little pretension to beauty. The first floor, which at home we should call the ground floor, contains various administrative offices and the resident's quarters. These latter are in the end of the building facing the river. The second floor is the "Nurses' Home." On the third are a number of separate rooms for the reception of patients; they are largely used for the isolation of those with acute respiratory infections, but are also utilised for the accommodation of patients of the better classes, or others who are receiving intensive treatment. No payment is taken for accommodation or treatment, and patients are selected without reference to their ability to pay, so that here, at all events, the "middle" class is as fortunate as the poor. The fourth, fifth and sixth floors are wards; they are arranged with a large open ward at each end, and the central part is occupied by small rooms for giving treatment to patients, or for the reception of those requiring quiet and special care. On the fourth floor there is a complete establishment for hydrotherapy, and on the sixth an oxygen chamber, some laboratories and the stenographers' rooms. The seventh is devoted to chemistry and bacteriology, and the eighth contains the cardiology station and a small operating theatre in which minor operations are done. There is a diet kitchen on the fifth floor, from which weighed diets are supplied to the patients whose metabolism is under observation. It is in charge of an expert dietitian, who constructs a diet according to the number of calories and proportions of protein, carbohydrate and fat ordered by the physicians. This was of the greatest value during the time that diabetes was being studied, and is now being utilised

in the investigation of nephritis. The basement contains the receiving room, the kitchens and the laundry, while in the sub-basement there is a large post-mortem room with suitable laboratory facilities. Between the Hospital and the Institute is a small building containing accommodation for infectious cases.

At any time four or five diseases are under study by the different services of the Hospital. These are selected from time to time by the Director of the Hospital, Dr. Rufus Cole, who acts in consultation with the heads of the departments. When a new subject is undertaken a team is gathered together, consisting partly of experts in the subject required, but also of partly-trained assistants, for it is part of the policy of the Institute to act as a training-ground for young research workers. At the present time the selected subjects are pneumonia and influenza, acute rheumatism, nephritis, auricular fibrillation, problems of cyanosis and dyspnœa, and chickenpox. The studies of the pneumonia service have been pursued for many years, and notable progress has been made, the most striking results being the discovery of the three definite serological types of pneumococci and the development of specific treatment for "Type I." Researches are being made on the presence and significance of the filter-passing organisms found in the respiratory tract in acute respiratory infections. This work is independent of that of Olitsky and Gates, who have been working on the same subject in the Institute. Exact data are being collected on certain of the clinical aspects of acute rheumatism, on the action of the salicylates and the nature of the joint affection in serum sickness, the serum-treatment of pneumonia providing a supply of material for the last. Persistent efforts are made to solve the riddle of the infective agent, but so far without success. Dr. Van Slyke is the head of the chemical department to which I am fortunate enough to be attached. The subject for clinical study is nephritis, but a number of biochemical problems are being worked out at the same time by the chemists. In the cardiac clinic the effects of digitan and quinidine in cases of fibrillation are being investigated clinically, and by means of electro-cardiograms which are taken daily or hourly should the circumstances require it so frequently. The study of cyanosis and dyspnœa invades all departments, but centres round the oxygen chamber. This chamber is large enough for a patient to be efficiently nursed in it, and by dint of many trials the ventilation system has been rendered so efficient that a patient can stay in it for a week without the atmosphere becoming foul. The air in the chamber is analysed by a most ingenious contrivance, which automatically abstracts a specimen from the chamber, analyses it and records the percentage of oxygen present on a chart. Several cases of pneumonia of types other than Type I have been treated with great relief to their symptoms, and probably with improvement in their chances of recovery.

All the members of the staff hold whole-time appointments. The senior members live outside the Hospital, but each service has one or more resident clinicians who are responsible for the care of the patients. The number of patients is small, for it is the object to work up a few cases with great care rather than to handle larger numbers with less thoroughness. With fifty patients the hospital is quite busy. A resident is in charge of from six to twelve patients, so that he has ample time to examine them every day and in every way and to assure them that they are getting better and better. Note-taking is greatly simplified by the services of a stenographer, who takes the notes down in shorthand at the bedside and returns them shortly after typed out. The resident undertakes all the routine pathology of his cases, which occupies a considerable part of his time. He has the assistance of excellent "lab. boys," who are styled "technicians," and are capable of carrying out many of the routine examinations under his supervision. The remainder of his time is spent in assisting the senior members of the staff in the more elaborate investigations and in attempting to work out problems of his own. No licence is required in this country for animal experimentation, so that this method of research is more readily available than at home; in fact certain general practitioners in the city are accustomed to type their pneumonia patients by means of mouse inoculations. The resident takes his turn to be "on duty," but the duty only lasts for twenty-four hours. The chief matter which will require his attention is the Out-patient Clinic. The only out-patients treated at the Hospital are discharged in-patients, and these are attended to by the physician in whose charge they were. But to this Hospital come all sorts of people, with maladies varying from a sore throat to malignant disease which has been given up as hopeless elsewhere and has been brought here for a final opinion. A few of these cases may be of the types under study, and these may possibly be admitted, but the great majority have to be referred to other hospitals or to private doctors. In the disposal of some of them a considerable amount of tact is required to avoid injury to the reputation of the Hospital, but in this we are assisted by a very efficient social service department. This clinic is an interesting but not always an easy or pleasant task.

In obtaining suitable patients the Hospital is largely dependent upon the co-operation of the practitioners in the city and surrounding country. A bulletin is sent out periodically to inform them of the cases which are being admitted. When a suitable case is referred to us one of the service concerned goes out to see that it comes up to the doctor's specification, and if so brings it back with him in the ambulance. By a discreet selection of patients he can see quite a lot of the city and its environs. Some of the tenement districts on the "East Side" could give points to the "District," especially in the hot weather. The condition of the streets often leaves much to be desired, for it is by no

means unusual to see dead horses lying in the gutter for a day if not longer, while dead cats, discarded furniture and bedding are habitually thrown out onto the streets. Some streets are set aside for children's playgrounds and closed to traffic, and on a hot summer's day it is a common sight to see happy and grubby bands of urchins in their bathing things cooling themselves under sprays attached to the fire hydrants.

There are two staff meetings every week in the working year. On Wednesday mornings the workers in the hospital meet; cases are shown, and the investigations which have been made on them described and explained, or chemical or bacteriological work which is in progress is presented for criticism and suggestions. Sometimes a demonstration of a new method is given. By these meetings the men in one department become acquainted with the work of the other departments; they may hear something which will be of use to them in their own investigations, or may be able to contribute experiences of their own to the discussion. A more formal gathering is held in the Institute on Friday afternoons, before which finished work is presented. Attendance of all the institute staff is expected on these occasions. Twice a month all the members of the Hospital staff, twenty to twenty-five in number, dine at the Hospital; afterwards there is an adjournment to the sitting-room and a session of the Journal Club is held. Everyone is prepared to give a *résumé* of a recent article and to discuss it for the general information of the Club.

No account of the Rockefeller Hospital would be complete without a tribute to the open-hearted welcome which the newcomer receives on his arrival, particularly if he is a stranger to this country. Even with the Irish maids and porters, who probably regarded me as an enemy alien, no "incidents" have arisen. I hear that before my arrival one of them declared that she should not attend to a "Johnny Bull"; but she does, and I have even been accused of being unduly favoured.

A CASE OF GENERAL PARESIS COMPLICATED BY ACUTE MENINGITIS DUE TO MICROCOCCUS CATARRHALIS.

By C. H. ANDREWES, M.B., B.S.(Lond.), AND W. E. LLOYD, M.R.C.S., L.R.C.P.,
From the Medical Unit.

THE patient was a man, æt. 47, unmarried, a window-cleaner, and was admitted on June 15th, 1922, having had a "fit" in the street. No details as to its onset and characters could be obtained. The man had apparently been in good health until the middle of December, 1921, when he was said to have had a "stroke." For the following four days he was "quiet and looked vacant," and he was left with some impairment of speech as well as weakness of the left arm and leg. This had persisted, but he was able to continue his work and had done so until admission. Since April, 1922, he had become quieter in his manner, his speech very thick, his gait unsteady and his habits unclean. There was no history of previous "fits."

On examination.—The patient was a well-built man with a very "flushed" complexion. He was in a semi-comatose condition but could be roused with difficulty; he breathed deeply with slight stertor. There was no smell of acetone or alcohol in his breath. His facial muscles were symmetrical, but the right pupil was larger than the left, and both reacted very sluggishly to light. There was no irregularity in the contour of the pupils and the fundi appeared normal. There was a little rigidity of the neck muscles but Kernig's sign was absent. As far as could be ascertained there was no paresis of either upper or lower extremity, and all the tendon reflexes appeared normal except that the right plantar response was indefinite in character. There were two patches of psoriasis on the right leg. The blood-pressure readings were, systolic 140, diastolic 95, and the urine contained a trace of albumin, and much sugar but no acetone bodies. Soon after admission the patient had three more fits each lasting about 30 seconds, which were definitely epileptiform in character.

DIAGNOSIS AND PROGRESS OF CASE.

Diabetic coma was thought of but ruled out as the urine did not contain acetone bodies. After the report of the spinal fluid had been obtained on June 17th, 1922, a diagnosis of meningococcal meningitis was made; this had to be modified later. By June 18th the patient had recovered the power of speech but had become very restless, and there was increasing rigidity of the spinal muscles. Daily lumbar punctures improved considerably the general condition of the patient. There was no photophobia at any time and no loss of tendon reflexes; the sugar in the urine cleared after the second day of admission. Throughout his stay in hospital the patient was incontinent of fæces and urine. His temperature at its highest reached 100·2°, and his pulse varied between 60 and 85. The mental attitude of the patient was abnormal from the beginning; this was at first attributed to the meningitis. As the latter improved the mental condition became worse, and by July 6th the patient's mind had become completely unhinged. He had delusions as to his previous employment and his surroundings. These increased up to July 14th, when the patient was discharged to a mental hospital.

Note on the Pathological Investigations on the Cerebro spinal Fluid.

The first specimen of cerebro-spinal fluid, withdrawn on June 16th, 1922, was colourless, turbid, and with a few flakes of clot. Globulin was present in excess and Fehling's solution was not reduced. 500 cells per c.mm. were present, made up as follows: 340 polymorphs, 110 lymphocytes, 50 endothelial cells. No organisms were seen in the film, but culture of blood-agar showed many colonies of a Gram-negative diplococcus and a few of a streptococcus. The predominant organism was at first assumed to be the meningococcus, but later was seen to have the characters of *Micrococcus catarrhalis*. Thus, colonies on blood-tryp-agar were obviously yellowish and difficult to emulsify (hence no agglutinations could be attempted). It differed from the meningococcus also in not fermenting glucose or maltose, though it grew well when hydrocele fluid was added to the media. It differed from most *M. catarrhalis* in that it would not grow on ordinary agar. In the absence of serological tests the diagnosis of *M. catarrhalis* from the sugar reactions alone must be regarded as provisional. The streptococcus gave the sugar reactions of *S. salivarius*. In a specimen of cerebro-spinal fluid removed on June 19th, 1922, numbers of Gram-negative diplococci, many of them intracellular, and a few streptococci were found in the centrifuged deposit, but further attempts at culture were unsuccessful. No further cocci were found in specimens taken on June 20th and 21st. By July 6th the fluid showed no abnormality beyond a spidery clot on standing and an excess of globulin. The Wassermann reaction in the blood and cerebrospinal fluid were strongly positive.

Discussion.—The diagnosis of general paresis was finally made on clinical and pathological grounds. The early acute symptoms were evidently due to the invasion of the meninges by *Micrococcus catarrhalis* and *Streptococcus salivarius*, perhaps from the nasopharynx. A local syphilitic lesion at the base of the brain may possibly have opened the way for this invasion. Examination of the nasal sinuses and nasopharynx threw no further light. Meningitis due to organisms such as *M. catarrhalis* and *S. salivarius*, which are commonly saprophytic, is of infrequent occurrence. Wilson has described a fulminant attack of meningitis in an infant due to an organism with the characters of *M. catarrhalis*. Arkwright has met with a case due to a similar organism, which he thinks may correspond to the *M. cinereus* of von Lingelsheim. This last author has also described cases of meningitis due to the allied Gram-negative diplococci, *D. pharyngis* and *D. flavus* II. Barker has met with meningitis due to *M. catarrhalis* complicating otitis media, and Forbes with an infection by another allied organism, *D. crassus*, in a case of fractured base. Dr. M. H. Gordon tells us of a case of non-fatal meningitis in a Canadian soldier during the war in which *Streptococcus salivarius* was recovered in pure culture; and fæcal streptococci have been found in meningitis by Wilson.

We are greatly indebted to Prof. Fraser for permission to publish the details of this case, and to Dr. Gordon for his kind assistance with the bacteriology.

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THEN AND NOW.

WE all know the danger of comparisons; for this reason the present writer has no intention of specifying the date referred to as "then"! If, however, one talks to very old Bart's. men, they will tell how at one time it was customary for a student to make his own arrangement with expectant mothers, and when the time arrived he light-heartedly undertook the task, carrying with him a pair of hands and no other *impedimenta*, relying entirely upon the fates and the gamp to provide the necessary adjuncts. Turning again to a generation not much senior to the present writer's, one hears there existed a wonderful house called "Mackenzie's," in which there was much revelry and some hard work. This house was generally inhabited by one extern, four or five midwifery clerks, and countless fleas—not to mention various other fauna. All this had changed before the writer appeared on the scene, and he in turn inhabited the present spacious quarters and went forth equipped with a bag containing bottles and sterilizer, and sometimes some cotton-wool.

It will thus be seen that there has been no sudden change, but a gradual transition to the present state of affairs. If a visit is now paid to the rooms apportioned to the midwifery clerks, we find that the majority of students have already been through the Labour Ward, and know considerably more than did the author of this article when he was first qualified. No longer is a student able to replace the placenta whence it came in ignorance that such a thing should not be done! He comes on the district with ideas of asepsis in midwifery, and he carries—or gets somebody else to carry for him—not only a midwifery bag with sterilizer and rubber gloves, but also a drum containing a sterile gown, five sterile towels, cotton-wool, gauze, umbilical dressings. When the last of these innovations was made it was feared that the list of wounded and missing among gowns and towels would be so appalling that one pessimist prophesied a total absence of such articles at the

end of six months! By the following simple device, and the whole-hearted co-operation of students, it has been found, however, that the loss during twelve months has been about 1 or 2 per cent. The present routine is as follows:

The porter, on receiving the district letter from the patient's friend, hurriedly goes to the middle room and picks up a book and a drum. These he takes to the clerk on duty, and having presented him with the drum of sterile gowns, begs him to sign his name in a space provided in the book, opposite the distinctive number of the drum. The responsibility for that drum and its contents now rests entirely with the dresser. As soon as the case is over he brings back the drum, with dirty towels, etc., inside, and is very anxious to get rid of the heavy responsibility which is upon his shoulders. He therefore goes to the middle room of the surgery, and depositing his casket at the feet of the nurse, proceeds to demonstrate to her that the full complement is there, and that nothing remains up his sleeve. He then requests the nurse to countersign, and thus rids himself of further responsibility. Should, however, he be unable to demonstrate the presence of all these towels, the nurse refuses to sign, and reports the fact to the extern midwifery assistant within the next twenty-four hours. This official then brings all his knowledge of the art of Sherlock Holmes to discover the missing article. Should he fail, he in turn is requested to notify the Assistant Physician Accoucheur in charge of the District, who notes such losses in the book at his weekly visit to the clerks' room. The object of this weekly visit is to try and help the students, and to answer any conundrums that may be put before him.

It will be seen from the above that there is a real effort being made to make the student realise that however filthy the surroundings, by taking trouble and a tin of sterile towels, he is able to transform a small area, roughly two square yards, into a heaven of cleanliness. The students appreciate fully the value of these innovations; and although on paper it would appear a cumbrous machinery of signing and countersigning, yet in practice—owing to the splendid keenness of the present-day student—the whole scheme works with absolute smoothness.

There are yet other innovations in regard to the extern. He is well equipped with instruments for which he is responsible, and for which he, when giving up office, takes good care to get a receipt from his successor. He is also provided with special drums of sterile dressings, with extra gowns, towels and leggings. In addition, he has at his disposal a bicycle fitted with a carrier.

Now, it is possible that if some old Bart.'s men read this article they will say—"This is all very nice, but do they get better results than we did in our day, when we never used gloves, and went on the District knowing nothing?" It is quite true that the results on the District have been good for generations; but people who talk like the before-mentioned gentlemen have really forgotten what did happen. If you ask them whether any temperatures occurred they will tell you that they didn't often take them; but they are quite sure they never had any sepsis. Well, it is merely a dispensation of Providence that memory is so short! There always has been sepsis when working under such untoward conditions, but the records of recent years do show a distinct improvement.

In 1921 no deaths due to sepsis occurred in patients from the District. Ten cases were admitted from the District for this condition, but all recovered. These results partly are due to the greater facilities given to students, partly to the greater knowledge they have before coming on the District, partly to the prophylactic vaccine which is given in all cases where manipulations have been carried out, partly to the Antenatal Department organised by Dr. Barris, but chiefly due to the splendid enthusiasm of the present-day midwifery student and extern midwifery assistants.

CLINICAL SARTORIAL SURGERY.

By SIR JAMES JERMYN BEAUGROOM.

Being the first of a series of lectures on the subject.

GENTLEMEN,—The subject to which I have the honour of introducing you in this course of lectures is undoubtedly the oldest branch of the surgeon's art. Although some writers have suggested that Adam wounded his right index finger while climbing the forbidden tree, there is no evidence that any treatment was carried out; whereas Eve, while trying to dodge the revolving swords of her angelic gaolers, is authentically reported to have lacerated the lateral folds of her apron. Were the reason for the first production of such a garment to hold good, it is obvious that some sort of suturing operation must have been performed.

So on down the ages, and the sartorial surgeon will be a social necessity until the millennium, when presumably the maker of musical instruments and the goldsmith will be the sole surviving professional gentlemen.

Pathological conditions of the clothes are usually grossly subdivided into congenital and acquired.

An example of the first division—imperfect migration of the collar-pin—I shall shortly show to you. Other lesions examplifying this division are imperforate stud apertures, absence of the postero-lateral pouch (known as the "hip-pocket"), retention of fœtal membranes in the shape of price-tickets (most frequently seen in the hospital class of patient), and abnormal pigmentation of the socks.

Of the acquired conditions by far the most important

group is the traumatic. Traumatic lesions are subdivided into external or true traumatic (a serious condition), and internal or Pharisaic, affecting such garments as pants, under-vests, or the soles of the stockings. This is a relatively benign condition.

In females the most frequent traumatic lesion seen in this hospital is dislocation of the shoulder strap.

New growths of the clothes are mere pathological curiosities.

Infections of the clothes are also rare, unless the harmless infections seen in certain classes are included. The most virulent infecting organism is the moth, and wholesale destruction of tissues due to this organism is seen in clothes of sedentary habits.

I have to show you two cases of considerable interest. The first is one of imperfect migration of the collar-pin. The pin is seen to have passed completely through the foramen on the right side of the collar, but to have failed to traverse the left foramen. The pin is seen to be hanging suspended from the right side of the collar and completely hidden by the tie.

This is a disabling condition. In some cases the points of the collar come to be folded upwards, thus exposing that delicate structure—the tie. Occasionally a volvulus has been produced where one point has been pulled downwards by a heavily-jewelled collar-pin whilst the other was freely mobile.

Ectopia of the collar-pin is sometimes seen, when the whole structure is found in the right waistcoat pocket, between the waistcoat and shirt, and sometimes even within the breech of the trousers. In some cases the pin is found to have passed through both foramina, but in front of instead of behind the tie.

In a few cases it has been impossible to locate the pin at all. It has been suggested that the structure was drowned in the liquor razori, or that Nature has tried her hand at organotherapy and had used the pin to ameliorate the even more serious deformity of congenital absence of the posterior brace-button.

The surgical treatment is obvious. A large proportion of cases recover.

The second case I wish to show illustrates the extreme importance of removing garments before undertaking surgical measures.

This is a boy, æt. 6, who, while playing at soldiers, lacerated his trousers in the region of the sacrum, a wound 6 in. long with irregular everted edges being produced. Patient consulted a female surgeon, who, after a short course of vigorous massage, proceeded to suture the wound with chromicised catgut, without removing the garment. On retiring to bed the patient himself discovered that very considerable adhesions had been produced between the trousers, shirt and pants, rendering it impossible for patient to remove his clothes.

I have not yet made up my mind with regard to treatment, and intend to ask the advice of my colleagues at consultation next Thursday.

Next week I hope to show a case of sinus leading from a lateral femoral pocket into the cavity of the trousers, which has persisted for many months, and caused the patient considerable loss of finance.

STUDENTS' UNION.

At a meeting of the Council of the Students' Union, the resignation of Mr. Huntly Gordon from the office of Senior Secretary was accepted, owing to his leaving the Hospital to go into business. Mr. W. Holdsworth was elected in his place, and Mr. E. S. Vergette was chosen to fill the post of Junior Secretary. Mr. A. B. Cooper was co-opted on to the Council as a representative of Constituency "A," in place of Mr. E. Coldrey, who resigned on appointment to the Junior Staff.

THE ANNUAL DANCE.

The Annual Dance is being held this year at Prince's Galleries, Piccadilly, on Tuesday, December 5th. Double tickets, 30*s.*; single tickets, 20*s.* Dancing, 9.30 p.m. till 3 a.m. Tickets can be obtained from any member of the Dance Committee or the Hon. Secs. (D. G. Martin, G. E. Burgess).

GOLF CLUB.

Final of Inter-Hospital Cup was played at Sandy Lodge on Monday, October 30th.

The St. Bart.'s Golf Club lost by the narrow margin of 4 matches to 5.

St. Bart.'s Golf Club.		St. Thomas's Hospital.	
S. R. Prall	0	Gardiner Hill	1
H. Smith	1	H. V. Coverdale	0
J. H. T. Davies	½	N. M. Jerram	½
J. Ness-Walker	½	F. Neilson	½
H. Houfton	1	R. Settick	0
J. Holmes	0	N. C. Bower	1
Prall and Holmes	0	Hill and Neilson	1
Smith and Davies	0	Coverdale and Jerram	1
Ness-Walker and Houfton	1	Settick and Bower	0
	4		5

Match *v.* Middlesex Hospital at Highgate on Wednesday, November 8th. Bart.'s won by 5 matches to 3.

St. Bart.'s Golf Club.		Middlesex Hospital.	
H. Smith	0	Barnet	1
J. H. T. Davies	0	Holford	1
H. Houfton	1	Thomas	0
J. Holmes	1	Morton	0
Barnes	1	Allen	0
Williams	0	Gray	1
Dalton	1	Greenwood	0
Kendall	1	Quinn	0
	5		3

At the Annual General Meeting on November 6th of the Golf Club the following officers were elected for the coming year:

President.—Mr. Girling Ball.
Vice-President.—Dr. George Graham.
Captain.—J. H. T. Davies.
Secretary.—H. Smith.
Committee.—J. Ness-Walker, H. F. Chillingworth, H. Houfton.

H. SMITH,
Secretary.

HOCKEY CLUB.

1ST XI *v.* HENDON.

This match was played on October 21st at Hendon, resulting in the Hospital losing by 5 goals to 2. Goals were scored for the Hospital by C. J. P. Grosvenor and J. E. Church. The game was fast, and considerable improvement was shown. The defence was good, although the halves were somewhat slow in getting rid of the ball.

1ST XI *v.* MALDEN.

The Hospital won its first match on October 28th against Malden at home. It was a well-contested game, resulting in a score of 3 goals to 2. Marked improvement was shown in the forward line; they are beginning to play more together and less individually.

1ST XI *v.* KING'S COLLEGE.

Played on November 4th at home, this match ended in a win for the Hospital by 18 goals to 0, C. J. P. Grosvenor putting up a record by registering 12 goals.

1ST XI *v.* ST. ALBANS.

This was an away match, and resulted in another win by 8 goals to 1. The game, however, was far better than the score indicates, and it was not until the last twenty minutes or so that a win was in any way certain.

A committee meeting was held on November 14th, and it was decided to appoint a Secretary for a 3rd XI. It is hoped he will be able to get some fixtures, although it is somewhat late in the season. There will, however, be some practice games for those who are in neither XI.

On November 2nd T. S. Goodwin, J. E. Church and J. G. Milner played for the United Hospitals against the Wanderers at Cambridge, J. E. Church registering one goal.

DEBATING SOCIETY.

Ordinary Meeting of St. Bartholomew's Hospital Debating Society held on October 19th, 1922, Sir THOMAS HORDER in the Chair.

Mr. J. C. L. DOYLE proposed "That the cinema has not been an influence for national welfare." He laid emphasis on the words "national welfare" and spoke mainly from two points of view—(1) the healthy and (2) the moral. He urged the need of healthy recreation, fresh air and exercise for the lower classes, and deplored the time spent by them in the "germ-laden atmosphere of the cinema." He said children stayed in "the pictures" from the time they commenced till the time they closed. "Imagine," he said, "that we could see all the organisms in the air and the effect that getting out of a spring seat has." When the seat flies up a whole shower of microbes flies into the face of the person behind." (Cheers.) He then dealt with the moral aspect of the cinemas—"Don't let us think of the question from *our* point of view but from that of the laymen." He emphasised the deleterious effect of bedroom scenes, not on us, for we are used to such demonstrations (laughter and loud cheers), but on the lay mind not used to such things. (More laughter.) He drew a picture of a film he had seen involving a "nasty ugly lord," a "pretty serving maid," and her lover, "the lame village cobbler." The end was obvious: the lord died smitten by the crutch of the cobbler. He forebore from describing further "sordid scenes." "We are all too used to them." (Cheers.) He dealt with inefficient censorship and the effect of the cinema on juvenile crime. He concluded by saying that "even such papers as *The Times* called the cinema an abomination." He sat down amid loud applause.

At this point the PRESIDENT gently rebuked the proposer for not addressing the Chair.

Mr. CRUDEN opposed the motion. He said he felt he could not support the motion, and, indeed, was going to speak against it. He had mentioned the subject for debate to a nurse and her reply had been "How ridiculous!" He dealt with the recreational, the educational, the social and moral benefits of the cinema. There is no home recreation in Bastwick Street, and where can the young man of Lever Street court the young lady of Bastwick Street if not at the cinema? The public house—an alternative—developed an evil syndrome—hyperchlorhydria, irritability and violence. The public parks are not safe nowadays. "I have," said the opposer, "myself refrained from entering a public park." He told a tale of what sort of things happened when there was no cinema. A lady of 83 arrived one wet, cold afternoon at the Ante-natal Department and made inquiry as to whether she was in a certain condition. After waiting three hours she insisted on being examined, and was thereupon reassured upon the subject. A clerk, being curious, asked her why she had come. She replied that it was so cold and miserable outside that she had come in to be in the warm and "out of the rain." (Loud cheers.) Such a thing was now unnecessary as she could go into a cinema. He said juvenile crime was not increased by criminal films and that children always cheered the hero. He also dealt with the moral and educational value of the institutions.

Mr. BALFOUR said "the eyestrain caused at the cinema is 'something terrible.'" (Groans.) He quoted several distinguished educationalists who would not allow children to visit the cinemas. He also said—"The bad effect on foreigners' opinion of our English womanhood was 'something awful.'" (More groans.)

Mr. MOORE dwelt on the commercial and industrial value of the cinema. "I have seen bedroom scenes—(loud cheers)—on the screen." (Groans.) "*Honi soit*," etc.

Mr. HARTSILVER said he appreciated the classical music heard at cinemas.

Mr. TAIT, of course, did not intend to speak. He opined that more infection was spread in the tubes than in cinemas.

Messrs. BROOKES, ROTH, ADAMS-CLARK, JAMIE, STANLEY JONES, CHADWICK SCOBELL and PRESS also spoke.

The motion was lost by 40 votes to 25.

D. S. COLDREY,
Hon Sec.

REVIEWS.

A TEXT-BOOK OF THE PRACTICE OF MEDICINE (including sections on diseases of the skin and psychological medicine). By various authors. Edited by FREDERICK W. PRICE, M.D. (Oxford Medical Publications.) (London: Henry Frowde & Hodder & Stoughton.) Pp. xxxvi + 1753. Price 35*s.* net.

There lies before us a new one-volume text-book of medicine, which definitely challenges the supremacy of "Osler" and "Taylor," and invites comparison with them—a truly difficult task for the reviewer. Its *format* is good; it is a little more ambitious than the older text-books, containing more pages; but it is printed on thinner paper and is therefore a little smaller aud definitely lighter than either; it costs five shillings more. The book is a purely London product; the twenty-six contributors, all of whose names command respect, are on the staffs of London hospitals, and all but two of the London teaching hospitals are represented. Five contributors are on the staff of St. Bartholomew's. In the main, one large section is written by one contributor or by two in collaboration.

There is a long section at the beginning of the book on immunity and immune therapy, for which Sir Thomas Horder is jointly responsible with Dr. John Matthews. A most useful section this, containing information which cannot readily be found elsewhere. Sir Thomas Horder has also written many parts of the second section (on general infectious diseases), as well as the article on infective endocarditis. Dr. Thursfield has written on diseases of the lymphatic system, the blood and the spleen; Dr. Langdon Brown and Dr. Geoffrey Evans together on diseases of the kidney and on vasomotor neuroses; and Dr. George Graham on diseases of metabolism, including gout and diabetes. It is not mere prejudice which makes us say that these contributions are all excellent.

The long section on diseases of the heart by the Editor is remarkably full; no less than twenty-nine electro-cardiographic and twenty-eight polygraphic tracings illustrate the text. The reader will find tropical diseases, skin diseases and psychological medicine as well treated as in many of the smaller books devoted specifically to these subjects; the last-named impressed us particularly favourably. The space allotted to different diseases is not always proportional to their importance; thus trench fever gets nine pages and bacillary dysentery less than two. Is it a spirit of prophecy which makes the editor include phlebotomus fever and dengue under spirochætal infections?

The section on the treatment of empyema did not greatly impress us. We read on p. 568 that there is no evidence that bile can be produced elsewhere than in the liver. If by bile are meant bile-pigments the statement is untrue; otherwise it denotes loose thinking.

Applied physiology is to the fore, though perhaps less than in the last edition of "Taylor." There are, however, many sections in which the pathology is very meagrely deal with. The book is eminently practical; it should all, particularly the pages on oral sepsis and the like, appeal strongly to the student, and even more to the practitioner.

ON DISEASES OF THE LUNGS AND PLEURÆ, INCLUDING TUBERCULOSIS AND MEDIASTINAL GROWTHS. By Sir R. DOUGLAS POWELL, Bart., M.D., etc., and Sir P. HORTON-SMITH HARTLEY, M.D., etc. Sixth Edition. (H. K. Lewis & Co.) Demy 8vo. Pp. 798. 36 plates and other illustrations. Price 42*s.* net.

This work was already a classic before the present joint authorship began; the present (sixth) edition more than ensures it maintaining its position. The value of the combined experiences of both writers, incorporating as they do the teaching and traditions of two large schools of medicine and the premier chest hospital, is illustrated in many ways that become apparent with a careful perusal of the book.

Of the fifty-four chapters in the book no less than sixteen of them, occupying two-fifths of the whole work, are devoted to pulmonary tuberculosis. This section is both full and thorough, and probably constitutes the best all-round treatise on the subject in the English language. It includes valuable accounts of every aspect of this important branch of the practitioner's work, as well as a large number of actual cases illustrating the author's own conclusions in regard to general principles, and which, we are glad to note, they have not hesitated to give. There is a useful chapter on "Spurious or False Hæmoptysis," instancing the classes of cases in which this important symptom confuses with the genuine hæmoptysis of phthisis. In connection with this subject we doubt the wisdom of summarising all cases of hysterical hæmoptysis as "feigned," and we cannot subscribe to the dismissal of them as "more or less downright attempts at imposture." The chapters dealing with cases suitable for sanatorium treatment and the principles underlying such treatment are specially useful. So also are those dealing with important complications, recurring hæmoptysis and its significance, and very chronic cases. In connection with the last-named subject we are impressed by the importance attached to cases illustrating prolonged "arrest" of the disease—cases running a favourable course quite independently of formal institutional treatment.

There is abundant evidence that the book has been brought thoroughly up to date in all subjects. The doctrine of "toxic idiopathies" was barely broached when the book was printed; it is therefore not a surprise that the chapter on asthma contains only a reference to it. But the sections on the surgical treatment of empyema, bronchiectasis and abscess of the lung are full of recent experience of technique, for much of which the authors thank Prof. Gask. Bacteriological references (edited by Dr. M. H. Gordon) form another instance of thorough revision of the last edition. (By the way, in speaking of the nine years that have elapsed since the fifth edition was published, the authors, in their preface, say that "in the course of this time the last word has been said on antiseptic methods in surgery and more tardily in medicine." We hope not!) In the pathology sections reference is made to Glun's recent work on the paths of infection in infants, and to Canti's confirmatory observations; Cole's efforts at grouping the pneumococci are also given explicit consideration.

The chapter on pneumonia is perhaps a little disappointing, especially in the matters of diagnosis of the nature of the infection and of treatment. We agree as to the important warning against overfeeding; but are 4 to 5 oz. of fluid every two hours (an equivalent of 50 oz. in the day) a sufficient allowance? But perhaps it is assumed that water should be given in addition? An exhortation to hygiene of the mouth is not omitted; it might have been stressed even more emphatically. We miss a reference to the value of treatment in the open air when conditions favour it. In diagnosis the value of "filming" sputa might have been referred to.

In the chapter on emphysema the clinical picture is non-existent, or is only represented by an illustrative case. This appears to us a pity, as giving the student a quite inadequate account of one of the commonest causes of cyanosis, dyspnœa and (in the subjects of hyperpiesis) of hæmoptysis. We also miss a reference to the acute emphysema of children.

Other omissions are a reference to the occurrence of hæmoptysis in actinomycosis of the lung, an account of the use of lung puncture in diagnosis and treatment, and a note upon pulmonary atheroma. But where there is so much good reading it is quibbling to find fault. A wise man has said there is no vanity like the effort to get everything into a book. In conclusion, one word in praise of the index, which is just as full and useful here as it is most often meagre and valueless. We have only come across one error: p. 652 should be p. 552 in the references to "prognosis in pulmonary tuberculosis."

[*We regret that this review has been unduly delayed.*—ED.]

RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

ADAMSON, H. G., M.D. "Melanosis Cutis, with Melanotic Carcinoma." *Proceedings Royal Society of Medicine*, September, 1922.

BROWN, W. LANGDON, M.A., M.D., F.R.C.P. Contributor to *A Text-Book of the Practice of Medicine*, by Various Authors, edited by FREDERICK W. PRICE, M.D., F.R.S.(Edin.). London: Henry Frowde & Hodder & Stoughton.

BURROWS, HAROLD, C.B.E., F.R.C.S. "Restoration of the Sunken Nose." *British Medical Journal*, October 14th, 1922.

CARVER, ALFRED, M.D., D.P.M.(Cantab.). "The Use and Abuse of Suggestion in Medicine." *Clinical Journal*, July 26th, 1922.

CONNOR, Lieut.-Col. F. POWELL, F.R.C.S. "Some Surgical Aspects of Filarial Disease." *British Journal of Surgery*, October, 1922.

DAVIS, HALDIN, F.R.C.S. "Case of Leprosy." *Proceedings Royal Society of Medicine*, September, 1922.

DRYLAND, LESLIE W., L.R.C.P., M.R.C.S., D.P.H. "Rupture of Quadriceps Treated by Suture." *British Medical Journal*, September 9th, 1922.

DUNDAS GRANT, Sir JAMES, K.B.E., M.D. "Specimen of Internal Auditory Meatus dilated and occupied by New Growth involving the Auditory Nerve." *Proceedings Royal Society of Medicine*, August, 1922.

ELMSLIE, R. C., O.B.E., M.S. "Accessory Bone representing Tubercle of Scaphoid of Foot." *Ibid.*, September, 1922.

—— "Madelung's Deformity of Left Wrist." *Ibid.*

EVANS, E. LAMING, C.B.E., F.R.C.S. "Case of Crush Fracture of Tenth Thoracic Vertebra." *Ibid.*

EVANS, GEOFFREY, M.D., F.R.C.P. Contributor to *A Text-Book of the Practice of Medicine*, by Various Authors, edited by FREDERICK W. PRICE, M.D., F.R.S. (Edin.). London: Henry Frowde & Hodder & Stoughton.

FRASER, FRANCIS R., M.D., F.R.C.P. "Rapid Digitalis Effects by Oral Administration." *Lancet*, September 30th, 1922.

FREEMANTLE, Lieut.-Col. F. E., O.B.E., M.P. "The Economics of Public Health." *British Medical Journal*, August 26th, 1922.

GALL, Major H., R.A.M.C. "The Catarrhal Phase." *Journal Royal Army Medical Corps*, August and September, 1922.

GIUSEPPI, P., M.D., F.R.C.S. "Errors in Diagnosis." *Clinical Journal*, August 30th, 1922.

GRAHAM, GEORGE, M.D., F.R.C.P. Contributor to *A Text-Book of the Practice of Medicine*, by Various Authors, edited by FREDERICK W. PRICE, M.D., F.R.S. (Edin.). London: Henry Frowde & Hodder & Stoughton.

GRIFFITHS, H. E., M.S., F.R.C.S. "Trauma as a Cause of Gastric Ulcer." *Lancet*, August 12th, 1922.

GROVES, ERNEST HEY, M.S., M.D., B.Sc.(Lond.), F.R.C.S. *A Synopsis of Surgery*. 6th Edition. Bristol: John Wright & Sons, Ltd.

HAYES, REGINALD, M.R.C.S. *Intensive Treatment of Syphilis*. London: Baillière, Tindall & Cox.

HEALD, C. B., C.B.E., M.D., M.R.C.P. "A Lecture on the Value of Respiratory Exercise." *Lancet*, August 19th, 1922.

HORDER, Sir THOMAS, M.D., B.Sc., F.R.C.P. Contributor to *A Text-Book on the Practice of Medicine*, by Various Authors, edited by FREDERICK W. PRICE, M.D., F.R.S.(Edin.). London: Henry Frowde & Hodder & Stoughton.

HOWELL, B. WHITCHURCH, F.R.C.S. "Case of Arthritis of the Hip in a Girl æt. 9." *Proceedings Royal Society of Medicine*, September, 1922.

HUME, J. B., F.R.C.S. "Congenital Diaphragmatic Hernia." *British Journal of Surgery*, October, 1922.

POWER, Sir D'ARCY, K.B.E., F.R.C.S. "Eponyms—Sir James Paget." *Ibid.*

PYBUS, FREDERICK C., M.S., F.R.C.S. *Surgical Diseases of Children*. London: H. K. Lewis & Co., Ltd.

—— "The Examination and General Surgical Treatment of Children." *Clinical Journal*, September 6th, 1922.

—— "Some Affections of the Genito-Urinary Organs in Children." *Ibid.*, September 13th, 1922.

—— "Some Infections of Childhood." *Ibid.*, September 27th, 1922.

—— "A Note on Two Cases of Gallstone Ileus." *Lancet*, October 14th, 1922.

REECE, RICHARD J., C.B., M.D., M.R.C.P., D.P.H. "Port Sanitary Administration: Its Development and its Relation to Public Health." *British Medical Journal*, August 26th, 1922.

ROLLESTON, Sir HUMPHRY, K.C.B., M.D., D.C.L., LL.D. An Address on the Clinical Laboratory in the Modern Hospital. *Lancet*, September 23rd, 1922.

RYLAND, ARCHER, F.R.C.S.(Edin.). "Malignant Disease of the Soft Palate; Removal by Simple Excision; Preliminary Ligature of the External Carotid Artery." *Proceedings Royal Society of Medicine*, September, 1922.

SCOTT, THOMAS BODLEY. *Endocrine Therapeutics*. London: H. K. Lewis & Co., Ltd.

SLADDEN, A. F., M.D. Laboratory Note to "An Outbreak of Trichiniasis," by D. A. RICE, M.B., B.Ch., R.U.I., and H. O. WILLIAMS, M.B., B.S., D.P.H., *Lancet*, October 14th, 1922.

SMITH, H. GORDON, M.B., B.S., D.P.H. "A Case of Diphtheria Complicated by Hemiplegia with Aphasia." *Ibid.*, August 19th, 1922.

SPENCER, W. G., O.B.E., M.S., F.R.C.S. "Pancreatic Fibrosis Obstructing Common Bile-Duct and Duodenum; Five Years' Active Life after Cholecystduodenostomy and Gastrojejunostomy before Death from Cancer." *British Journal of Surgery*, October, 1922.

—— "Two Cases of Rupture of Rectum communicating with Peritoneal Cavity." *Ibid.*

STOTT, A. W., M.B. "Case of (?) Erythromelalgia." *Proceedings Royal Society of Medicine*, September, 1922.

SIRETTON, J. LIONEL, M.R.C.S. "Cæsarian Section." *Practitioner*, September, 1922.

EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

The following degree has been conferred:
M.D.—A. H. Southam.

Final B.M., B.Ch. Examination.

Materia Medica and Pharmacology.—R. E. D. Cargill, C. L. Elgood, C. A. H. Green.
Pathology.—A. Q. Wells.
Forensic Medicine and Public Health.—H. A. Gilkes.
Medicine, Surgery and Midwifery.—W. Champneys, R. F. Johnstone, T. L. Ormerod.

Diploma in Public Health.

Part I.—C. Dunscombe.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:
M.D.—H. W. Hales, F. G. Lescher.
M.B., B.Ch.—C. S. Atkin, A. E. Roche.

Diploma in Medical Radiology and Electrology.

At the examination held in July the following were successful:
Part II. Radiology and Electrology.—B. Grellier, A. Lambadarides.

UNIVERSITY OF BRISTOL

Examination for D.P.H. Part I only.—F. P. Mackie.

ROYAL COLLEGES OF PHYSICIANS.

The following have been admitted *Members:*
R. H. Coombs, M.D., D. W. Winnicott, L.R.C.P.

ROYAL COLLEGES OF PHYSICIANS AND SURGEONS.

Diploma in Public Health.—D. S. Brachman, E. M. ElKirdany, H. Toms.

Diploma in Psychological Medicine.—J. J. Gasperine.

CONJOINT EXAMINING BOARD.

First Examination, October, 1922.

Chemistry.—C. P. Madden, H. C. Thomas, P. R. Viviers, J. S. H. Wilson.
Physics.—C. H. A. Carty-Salmon, J. T. C. Gray, A. Liveris, W. V. Roach.
Biology.—F. Brodahl, R. E. Norrish, J. S. H. Wilson.

Second Examination.

Part I. Anatomy and Physiology.—J. D. Allen, D. J. Brims M. Bryer, J. L. C. Doyle, R. A. Foucar, A. W. Gardner, R. Green, A. R. Hill, G. E. Hughes, D. Imber, F. F. Imianitoff, A. J. Moody, H. A. Nicholls, C. P. O'Brien, W. F. H. Quennell, H. N. Seymour-Isaacs, N. L. Simpson, R. S. Tooth.
Part II. Pharmacology and Materia Medica.—J. C. H. Baird, S. B. Benton, M. Bryer, S. M. Coleman, E. W. P. Davies, P. B. P. Mellows, J. E. C. Morton, T. Rees, P. R. Viviers, T. J. Wilson.

The following have completed the examinations for the Diplomas of M.R.C.S., L.R.C.P.:
M. A. Afifi, E. B. Brooke, A. W. Brown, N. E. D. Cartledge, E. F. Chapman, W. E. Howell, M. B. Jay, E. Liston, A. E. Lorenzen, A. W. Marrison, J. A. Morton, K. Olafsson, H. Summers, A. H. C. Visick.

ROYAL COLLEGE OF SURGEONS OF EDINBURGH.

Examination for Diploma of *Fellow:*
B. G. Melle.

APPOINTMENTS.

CHANDLER, F. G., M.A., M.D., M.R.C.P., appointed Assistant Physician, Charing Cross Hospital.
GRIFFITHS, H. E., M.S.(Lond.), F.R.C.S., appointed Surgical Registrar to All Saints' Hospital, Vauxhall Bridge Road.
LAING, J. NIVEN, B.Sc., LL.B., M.B., M.R.C.S., appointed Deputy Coroner for the County Palatine of Lancaster (Salford Hundred District).
MARRISON, A. W., M.R.C.S., L.R.C.P., appointed House-Surgeon to the Stamford and Rutland Infirmary, Stamford.
SHAH, Capt. J. M., M.B.E., I.M.S., appointed Deputy Assistant Director-General, Indian Medical Service, Delhi.
WILLIS, F. E. SAXBY, M.C., M.D.(Lond.), M.R.C.P., appointed Physician to Out-Patients, Hampstead and North-West London General Hospital.

BIRTHS.

CHANDLER.—On November 15th, to Marjorie, wife of Dr. F. G. Chandler, of 86, Harley Street, W., and 4, Downshire Hill, Hampstead—a son.
CUNNINGTON.—On September 16th, to Drs. C. Willett and Phillis E. Cunnington, Tatchley House, Dollis Avenue, Church End, Finchley, N.—a daughter.
MACKAY.—On September 24th, at 29, Warrior Square, St. Leonard's-on-Sea, Norah, the wife of E. C. Mackay, M.D., of a son.
PETERS.—On September 10th, at Charterhouse Lodge, Grantchester, Cambridge, to Frances, wife of Dr. R. A. Peters—a son.
SYLVESTER.—On November 20th, at Leiston, Suffolk, the wife of Herbert Mayris Sylvester—a son.

MARRIAGES.

CHURCHILL—HAROLD.—On November 18th, at St. James's, Spanish Place, by the Rev. Canon Hyland, Henry J. Churchill, elder son of Mr. H. L. Churchill, C.M.G., H.B.M.'s Consul-General at Genoa, and Mrs. Churchill, to Kathleen Mary, elder daughter of the late Dr. John Harold and Mrs. Harold, of Manor Lodge, Milford, Surrey.
COOK—SCHOFIELD.—On October 5th, at St. Lawrence, Mickleton, by the Rev. G. R. Peak, uncle of the bride, and the Rev. F. E. E. Arthier, Vicar of the Parish, Philip Nield Cook, M.B., son of the late Dr. Nield Cook, of Calcutta, and Mrs. Cook, 35, Webster Gardens, Ealing, to Mona Frances, youngest daughter of Mr. and Mrs. Frank Schofield, of Mickleton Lodge, Mickleton, Glos.
GREEN—WHITEWAY.—On Tuesday, November 21st, 1922, at St. Columba's (Church of Scotland), Pont Street, Colonel Bernard Charles Green, C.M.G., T.D., D.L., late commanding London Scottish, to Marguerite Mary Whiteway, daughter of the late Captain Whiteway, R.N.R., and Mrs. Whiteway, of 190, Earl's Court Road, S.W. 5.
HEATH—HARRISON.—On August 31st, at St. Alkmund's Church, Derby, by the Rev. J. S. Wilding, M.A., Vicar, assisted by the Rev. H. Blight, Rector of Churchstanton, Devon, George Edwin, Surgeon Lieut-Commander, R.N., elder son of Mr. and Mrs. Edwin Heath, Derby, to Alice Evelyn, daughter of Mr. and Mrs. J. Thornton Harrison, Derby.

DEATHS.

BECK.—On October 30th, 1922, at Bromyard, Edward Ashton Anthony Beck, M.A., M.B., elder son of the late Edward Ashton Beck, Master of Trinity Hall, and Mrs. Beck, of Malvern, aged 45.
BURD.—On November 2nd, 1922, at Carnarvon House, Swanage, Edward Lycett Burd, M.D., formerly of Castle House, Shrewsbury.
BRUNT.—On October 29th, 1922, at Morland House, Leek, Staffs, Major E. H. Brunt, M.B., R.A.M.C. (T.F.).
MORSE.—On November 9th, 1922, Edward Morse, L.R.C.P., L.R.C.S. (Bart.'s), of Great Torrington, Devon, aged 65.
LLOYD.—On November 23rd, 1922, at Ashcroft Drayton, Somersetshire, Surg. Lt.-Col. John Daniel Lloyd (late of Chirk), aged 72.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor,* ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C.

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